Washington State Health Care Authority
Public Employees Benefits Board

Request for Addition of Extended Dependent to Medical, Dental, or Life Insurance Plans

Guidelines for Extended Dependent Approval

An extended dependent is a child who is not your child through birth, adoption, marriage, or a qualified same-sex domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild or a niece or nephew for whom you are the legal guardian or have legal custody.

The following are guidelines for determining if the child you want to enroll qualifies as an extended dependent. If these guidelines are met, the child may be eligible; however, the actual determination will be made by Health Care Authority using the information on this form and a copy of the legal document you submit with the form.

1. The child must be living with you full-time in a parent-child relationship. A parent-child relationship is one in which the child's biological parents or stepparents are not living in your home and you are assuming the role of parent.
2. You must provide a court order signed by a judge or an officer of the court showing that you have legal custody, guardianship, or temporary guardianship.
3. The child must not be a foster child for whom support payments are made to you through the Department of Social and Health Services (DSHS) foster care program.

IF THE CHILD DOES NOT MEET THE ABOVE REQUIREMENTS,
***THE CHILD IS NOT ELIGIBLE* FOR COVERAGE AS AN EXTENDED DEPENDENT.**

- **Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.**
- **Please make a copy of the completed form for your records.**

Subscriber Information

Agency/Sub Agency | ❑ New ❑ Recertification

Last name	First	Middle initial	Social security number

Mailing address	City	State	ZIP Code

Work phone number	Home phone number
( )	( )

Dependent Child Information

I request the following child be continued or added on to my coverage:

❑ Medical/Dental (New applicants must attach a completed Medical/Dental Coverage form.)
❑ Life Insurance Part B Basic **or** ❑ Life Insurance Part E with dependent
(You must attach a completed *Life Insurance Enrollment Form.)*

Last name	First	Middle initial	Social security number

Date of birth (mm/dd/yyyy)	❑ Female ❑ Male	Relationship to subscriber

Does this child live with the subscriber?	If yes, when did the child begin living with subscriber? (mm/dd/yyyy)	If no, with whom does the child live?
❑ Yes ❑ No		

(continued on back)

If the answer to the following question is "No," the child does NOT qualify for coverage as an extended dependent.

Is the subscriber acting in the role of a parent to the child? ❑ Yes ❑ No

If the answer to any of the following questions is "Yes," the child does NOT qualify for coverage as an extended dependent.

Do either of the child's parents live in the subscriber's home? ❑ Yes ❑ No

If no, in what city and state do they reside? (If unknown, please state unknown.)

Mother: _____ Father: _____

Is anyone receiving payment under the Washington State Department of Social and Health Services foster care program for this child? ❑ Yes ❑ No

Is this child eligible for this program? ❑ Yes ❑ No

Please explain circumstances under which this child has been added to your household: _____

_____

_____

_____

It is the responsibility of the subscriber to notify the Health Care Authority if there are any changes in the extended dependent status throughout the year.

A copy of legal custody, guardianship, or temporary guardianship signed by a judge or the officer of the court for this child MUST be provided with this application.

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I declare that to the best of my knowledge and belief that the information provided by me on this form is true and correct and that all eligibility requirements have been met. I understand that I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. I understand that failure to provide accurate information or to update information in accordance with PEBB rules may result in loss of coverage as of the last day of the month in which eligibility was met. A deposit of premium does not guarantee coverage and will be refunded if the dependent is determined to be ineligible for coverage.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Subscriber's signature _____ Date signed _____

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2833 or online at **www.hca.wa.gov**.

Mail completed form to:

Washington State Health Care Authority,
P.O. Box 42684, Olympia, WA 98504-2684
1-800-200-1004